Letters

CMAJ publishes as many letters from our readers as possible. However, since space is limited, choices have to be made, on the basis of content and style. Letters that are clear, concise and convenient to edit (no longer than two double-spaced typescript pages, or 450 words) are more likely to be accepted. Those that are single-spaced, handwritten or longer than 450 words will usually be returned or not published. We reserve the right to edit letters for clarity and to abridge those that are unduly long or repeat points made in other letters, especially in the same issue.

Informed consent to HIV testing

Approval by the CMA General Council of the recommendation "that testing for HIV serology be carried out with the patient's informed consent wherever possible", as cited within the report on the CMA's 1988 annual meeting (*Can Med Assoc J* 1988; 139: 662–668), on page 666, establishes a dangerous precedent that I feel is not in the best interests of the patient, the public or the profession, for the following reasons.

- As outlined in an editorial in the *British Medical Journal*,[1] "there is no case law directly on the question of consent to testing, and the cases discussed by [British Medical Association legal advisers] all turn on the question of consent to treatment rather than specifically to testing".
- A patient is offered the option of denying reality: refusing a diagnosis. As emphasized by Kleinman,[2] denial by physicians regarding testing is also not uncommon.
- To impose needless anxiety and suffering before being certain of a diagnosis is cruel. I cannot think of any other serious disease for which a diagnosis is entertained and communicated before all the available evidence is to hand.
- The first principle of containment of any infectious disease epidemic is case-finding. If case-finding of asymptomatic infection cannot be done, the epidemic cannot be controlled. Relying on voluntary measures is particularly dangerous. Voluntary testing based on active case-finding and self-identification failed to identify 24 of 28 HIV-infected mothers in New York.[3]
- It is very much to the personal advantage of an HIV-positive individual to know his or her status, since life-threatening infections and immunosuppressive events may be appropriately avoided.[4]

A particularly sinister aspect of AIDS is its long latent period. Failure to diagnose HIV infection in its asymptomatic stage may put thousands of innocent third parties at risk. Mishandling of the situation may haunt our children's children on into the 21st century.

I feel strongly that testing should be encouraged at the first whiff of suspicion and that there should be no legal constraints on HIV testing. Ironically, by being designated as having a special status, AIDS rather than the public has been protected.

James E. Parker, MB, FRCPC
303–2151 McCallum Rd.
Abbotsford, BC

References

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2. Kleinman I: Transmission of human immunodeficiency virus: ethical considerations and practical recommendations [E]. *Can Med Assoc J* 1987; 137: 597–599
3. Krasinski K, Borkowsky W, Bebenroth D et al: Failure of voluntary testing for human immunodeficiency virus to identify infected parturient women in a high-risk population [C]. *N Engl J Med* 1988; 318: 185
4. Konotey-Ahulu FID: Surgery and risk of AIDS in HIV-positive patients [C]. *Lancet* 1987; 2: 1146

Stress among emergency medical staff: the US solution

The letter from Dr. Kendall Ho and the response from Dr. Leon Phipps (*Can Med Assoc J* 1988; 139: 1034–1035), author of "Stress among doctors and nurses in the emergency department of a general hospital" (*ibid:* 375–376), discuss the facts that patients often desire admission to hospital when their medical condition doesn't warrant admission, thus creating tension and spawning the occasional "social admission", that patients validly needing admission may be stuck in the emergency department because there are no inpatient beds and that patients use the emergency department for nonemergency conditions. Ho and Phipps blame hospital administrators and general practitioners respectively for most of the problem and suggest that more money be spent on educating the public as to the function of an emergency department.

I do not believe that this advice is sound, since members of the public do not pay directly

for unnecessary services that they demand, since there is a financial incentive for physicians to see patients in the emergency department as opposed to the office and since hospitals are funded according to a global budget, so that it is in their best interests to see many patients without emergency conditions in the emergency department (thus the numbers of outpatient visits are inflated) and to have beds full at all times.

My advice to health care organizers is based on my knowledge of the US health care system, which seems to be on the right track toward solving many of the nagging problems that threaten to undermine the Canadian system.

- Patients who use the emergency department for non-emergency conditions should be forced to pay for the service. The major US health insurance companies audit every visit to an emergency department, and if the service was not warranted they won't pay the bill.
- Doctors who treat non-emergency cases in the emergency department should not be allowed to bill the call-back fee to the emergency department. In British Columbia this fee is $62.50. This would mean that if a doctor practises across the street from the hospital and walks over to see a child with otitis media in the emergency department he would not collect this fee but his usual $21.25.
- Canadian hospitals need effective utilization reviews and should have their funding radically changed to more realistically reflect what they actually do. The US system of diagnosis-related groups, whereby a hospital is reimbursed for taking care of a patient on the basis of the ultimate diagnosis and the average stay for that problem, stimulates effective resource management and utilization review, since hospitals no longer get paid for days that a person doesn't really need to be in hospital.

There will be no improvement in the Canadian system unless patients, doctors and hospital administrators begin to realize that medical care is not free and unless governments have the guts to change the way they manage our tax dollars.

Robert H. Brown, MD
35283 McKee Pl.
Abbotsford, BC

Licensure: Competence to do what?

In the Publisher's Page of the Nov. 15, 1988, issue of *CMAJ* (139: 927) Dr. Bruce P. Squires gets to the heart of the critical issue confronting medical licensing authorities. Is the concept of general medical licensure tenable in the face of increasing differentiation in the practice of medicine?

Most of the foundation of medical knowledge and skill necessary to all medical disciplines should be laid by the end of medical school. Postgraduate education should be directed toward development of specific clinical competencies deemed to be essential to the planned nature and scope of practice. If medical licensing bodies are to meet their legislative obligation to protect the public interest, we must be able to credibly measure those clinical competencies before granting licensure. At present we are not able to do so.

The Quebec model of restricting preregistration training to two well-defined pathways is eminently logical, because those pathways are designed to prepare trainees for defined medical careers. They are based on sound educational objectives and have credible in-training evaluation mechanisms and well-standardized end-point assessment processes. Such claims cannot be made for any third pathway to licensure.

Our postgraduate education system must have sufficient capacity to assure all graduates of Canada's medical schools of the